CHILD HISTORY FACT SHEET

PATIENT NAME:	SPECIAL INFO ABOUT ME:		
PATIENT NAME: DOB:			
Religion:Nationality:			
Marital status of parent(s): married separated divorced	CAREGIVERS:		
remarried widowed single	Caregiverrelationship to child		
Child resides with: parent(s) mother father guardian	Caregiverrelationship to child DOB://SS#		
foster parent other	Address:		
DNR STATUS:	Phone(H): Phone(W):		
(DNR order should be clearly placed in chart)	Education: Literacy:		
	Disabilities:		
People whom the child presently resides with:	Employment:Hours:		
Name: Age: Relationship:			
	Caregiverrelationship to child		
	DOB:// SS#		
	Address:		
	Phone(H): Phone(W):		
TRANSPORTATION:	Education: Literacy:		
Handicap sticker:	Disabilities:		
Transport Company	Disabilities:Hours:		
Transport Company: Phone: Fax:			
FROME FAX:			
Special considerations:	0.1 0 : /0		
TOVIGNIG	Other Caregivers/Contact persons:		
HOUSING:			
INSURANCE	PROGRAMS		
Primary Ins:	•Early Intervention Services:		
ID#:			
Subscriber:	Case Mgr: Phone:		
Phone #:	•MRDD Services:		
Phone #:	-WRDD Scivices.		
Case Mgr:	Coss Mary Phones		
Secondary Ins:	Case Mgr: Phone:		
ID#:	•Family Resources:		
Subscriber:	•WIC: Office:		
Phone #:	Phone: Fax:		
Case Mgr:	Hospice Provider:		
Medicaid: (type)	Contact:		
ID#:	Phone:Fax:		
Phone #:	•School:		
Case Mgr:	Phone: Fax:		
PRCMH:			
BCMH:	Othory		
ID#:	•Other:		
Phone #:			
Case Mgr:			
SSI:			
Other:			
HOME CARE AGENCY	SPECIALISTS:		
	was and an annual and		
Name: Fax:	•MD: Division:		
	•MD: Division:		
Hours/Shifts:	Phone:Fax:		
Services Provided:	Contact:		
Supervisor:	•MD: Division:		
Name:	Phone:Fax:		
Phone: Fax:	Contact:		
Hours/Shifts:	•MD: Division:		
Services Provided:	Phone: Fax:		
Supervisor:	Contact:		
	- Continuer		

		•MD:	Division:	
DME		Phone:	Fax:	
Name:	Contact:	Contact:		
	Fax:	•MD:	Division:	
Supplies provided: _		Phone:		
		Contact:		
	Contact:	•MD:		
Phone:	Fax:	Phone:	Fax:	
Supplies provided: _				
		•MD:	Division:	
	Contact:	Phone:	Fax:	
Phone:	Fax:			
Supplies provided: _			Division:	
		Phone:	Fax:	
		Contact:		
THERAPIES			Division:	
OT Provider:	Contact:	Phone:	Fax:	
Phone:	Fax:	Contact:		
Frequency:		•MD:	Division:	
	Contact:		Fax:	
Phone:	Fax:			
Frequency:				
ST Provider:	Contact:			
Phone:	Fax:			
Therapies at school:				
	S TO FAMILIES:			
•Electric Co:				
·Water/Sewage: _			6	
·Fire Department:				
·Telephone Co:				
SUPPORT AND R	ESOURCES FAMILY RELIES	ON:		
			7	